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Health Care Reform Issue Brief

ISSUE 7, MARCH 2011

Helping Government Serve the People.®

MAXIMUS

The "Basic Health Plan" Option in the Affordable Care Act

The Affordable Care Act (ACA) contains several major mechanisms that help families with incomes at or below 400-percent of the federal poverty level (FPL) access affordable employer-sponsored coverage. Most of the national attention to these mechanisms has focused on the American Health Benefit Exchange (AHBE), while the Basic Health Plan (BHP) has produced considerably less discussion and interest.

In our continuing effort to help states consider their full range of options under health care reform, MAXIMUS is providing insights on ways states can use the BHP option to create a family-oriented approach to coverage in the CHIP income range; reduce health insurance expenses for families in that group (compared to what they would otherwise spend in the AHBE); and leverage existing CHIP-related operational infrastructures.

Basic Health Plan Operational Features

The BHP becomes a more attractive option to state policymakers if the federal government promotes state flexibility and avoids being prescriptive about most operational and budgetary decisions. Although the federal law gives the HHS Secretary considerable leeway in how to define the BHP statutory framework through informal guidance or formal rulemaking, they have not provided much direction to date.

However, the existing statutory language facilitates consideration of the relative pros and cons of BHP within the framework of an overall ACA implementation strategy. The key features to keep in mind are:

- **Eligibility.** If a state chooses to adopt the BHP model, the people who qualify must receive coverage under the plan. In other words, a person who meets the BHP eligibility criteria cannot "opt out" and choose to receive subsidized coverage through the AHBE instead. A person who meets all of the following criteria qualifies for BHP coverage:
  - Have a family income in the 133-200 percent FPL range and not qualify for Medicaid or CHIP* -or- have a family income below 133-percent FPL and be a legal immigrant (subject to the five-year waiting period)
  - Younger than 65 years of age
  - Uninsured or have access to employer-sponsored coverage that is unaffordable (using the ACA definition of affordability)

  **Children in the 133-200 percent range who would otherwise qualify for CHIP may be covered in a BHP only under the condition — that the state's federal CHIP allotment runs out. This could occur if Congress fails to provide funding beyond 2015 or if a state's CHIP enrollment exceeds the level at which federal matching funds are available.*

- **Funding.** Under a BHP, the federal government provides a lump-sum payment equal to 95-percent of what it would have spent on tax credits and cost-sharing subsidies for the applicable population within the state's AHBE. The early indication from federal officials is that HHS would make an up-front annual BHP payment to a state based on the best available cost and enrollment projections. This payment would be reconciled later with the actual BHP enrollment and associated AHBE tax credits and cost-sharing subsidies, with any adjustment applied to a subsequent annual payment.

  While definitive guidance has not yet come from HHS, it is likely that federal BHP funds can also be used to pay for the administrative costs associated with a BHP (such as eligibility determination, enrollment processing, customer service and premium payment processing).

  Some people have interpreted the 95-percent calculation to mean that a state with a BHP is liable for the remaining costs, but this is only true if the cost of BHP coverage equals that of the AHBE, a scenario that a state could easily avoid based on its health plan and provider reimbursement assumptions. A state could establish a BHP with payment assumptions explicitly below commercial rates and thus is likely to produce an overall economic model in which the federal payment covers all BHP costs.

Taking that logic even further, if a state implements a BHP that approaches Medicaid payment levels, the additional savings could be passed on to families in the form of lower monthly premiums and cost-sharing (compared to what they would otherwise pay in the AHBE, even after the tax credit and federal subsidy is included). This possibility is underscored in a recent paper prepared by the Urban Institute that projected Medicaid-equivalent provider rates would produce BHP costs that are 30-percent less than the amount the federal government would owe a state under the BHP calculation (assuming the AHBE is tied to commercial market rates).

In some states CHIP provider rates fall somewhere between Medicaid and commercial insurance, so they could also be proxy for a BHP model in which the federal 95-percent allotment is sufficient to fund the entire program, although there might be little or no additional cost savings to pass on to enrollees.

If the provider rates are set sufficiently low to fully offset the cost of a BHP, the federal contribution becomes a de facto block grant without a matching requirement. It is important to note, however, that the use of the federal funds is limited to direct BHP costs. The funds must be maintained in a separate "trust fund" account and may not be used as a source of match for other federal programs nor to support other, non-BHP expenses.

- **Coverage.** The BHP benefits package must meet the minimum requirements of a coverage policy offered through the AHBE (although a state could offer a more robust BHP package at its discretion) and consumers may not be charged higher co-pays, deductibles, or co-insurance than what they would have paid in the Exchange. When feasible, a choice of plans must be offered and a managed care delivery model is preferred. Statutory requirements mandate that BHP health plan or health insurer contracts include provisions for innovative care delivery and quality of care performance measures.

  While an AHBE has considerable flexibility in how it obtains or assembles coverage from interested insurers and health plans, a BHP must be based on a limited number of insurers or plans obtained through a competitive procurement.

- **Financial costs to families and individuals.** The financial cost of BHP coverage to an eligible individual or family cannot exceed what the person/family would have paid for the second-lowest priced silver health plan offered through the AHBE. Limits on cost sharing must also correspond to those available to families below 200-percent FPL within the Exchange.

  As noted in the "Funding" discussion above, a state could also establish a provider reimbursement policy that is expressly designed to produce even lower premiums and cost-sharing requirements than the silver plan level.

- **Coordination with Medicaid and CHIP.** While ACA mandates application and eligibility coordination between Medicaid, CHIP and AHBE, the BHP language goes further. In addition to application, eligibility and enrollment functions, ACA also requires the coordination of health benefits. While this is a fairly generic concept, it could be interpreted to mean that health plan and provider networks offered through Medicaid and CHIP should reflect those offered through the BHP as well.

Principal BHP Opportunities and Considerations

- **Continuity-of-care within a family.** The BHP may offer the most appeal to a state that has a CHIP program that is separate from its Medicaid program, with income criteria comparable to the BHP requirements. In that policy environment, CHIP and BHP could combine operations, with coverage for all eligible family-members through the same health plans and a single monthly payment to cover the premiums for all family-members. The programs would also be seamlessly joined into a single program brand or identity and combined customer service channels.

  While the funding streams would be different, the two programs would appear as one from the family's perspective. Management of separate funding streams across different enrollee populations is a relatively straightforward administrative task that MAXIMUS already handles accurately and cost-effectively in several states, including the largest comparable program in the country, California Healthy Families.

- **Less confusion for consumers and reduced risk of coverage gaps.** Rather than having family members covered by multiple programs with different eligibility rules and enrollment timeframes, a single-set of policies applies to all in the 133-200 percent FPL group (with immigrants subject to the five-year waiting period and incomes below 200–percent FPL). This simplifies communication, education, outreach and annual renewal efforts.

- **Leveraged existing infrastructure.** Where a state has already outsourced its CHIP administrative processes, the arrangement could easily be expanded to incorporate the BHP population, providing the

opportunity to maximize the benefit of the state's existing investment in its third-party administrator (TPA) arrangement.

- **Lower CHIP health plan costs.** A state can choose to jointly procure its CHIP and BHP health plans to ensure comparable provider network offerings across both programs. The relatively large scale of this procurement is likely to result in lower CHIP rates, producing cost savings for the state relative to its matching funds.
- **Future program continuity.** If CHIP is not reauthorized in 2019 or not funded past 2015, the BHP could be expanded to incorporate the eligible CHIP population, allowing the infrastructure and service-delivery mechanism for these children to remain largely intact (albeit with a different funding stream and underlying program identity).
- **Reduced provider participation.** As noted above, a provider reimbursement structure that is lower than a commercially-oriented AHBE is a fundamental assumption for any state that wishes to implement a BHP solely with the federal contribution. In most health care markets, provider participation and provider rates are closely correlated, which means AHBE enrollees may have access to provider networks that are more robust and inclusive than those in a BHP. Lower reimbursement rates in the BHP are also likely to produce discontent in a state's provider community, at least initially and perhaps over the longer term as well.
- **Welfare stigma.** If a state adopts the BHP approach to produce lower family premiums and cost-sharing requirements, the public may perceive that the BHP is closer in form and substance to a "welfare" program than the AHBE, even though the latter also involves tax credits and cost-sharing subsidies. To address the "welfare" image, many CHIP programs have established effective and innovative branding, cost-sharing (in contrast to Medicaid, which is free), and streamlined eligibility processes (a significant distinction in states that continue to rely on a traditional caseworker model for Medicaid screening).
- **Potentially higher AHBE premium costs.** Just as a linkage between the BHP and CHIP could drive down a state's CHIP matching-fund costs, the reverse could happen with the AHBE. The demographics of the BHP population are likely to be younger, and therefore healthier, than the relatively higher-income AHBE population. While it is too early to accurately predict the impact of this demographic disparity on the premium costs for an AHBE, it is possible that that the actuarial profile of an AHBE enrollee will produce higher per-family and per-individual costs if it operates in parallel to a BHP, compared to an AHBE with eligibility starting at 133-percent FPL. If this happens, the higher premiums will adversely affect AHBE enrollees (whose premiums will be higher) and the federal government (in relation to the tax credits and cost sharing subsidies). State budgets should be unaffected.

Background on Relevant MAXIMUS Experience

We offer these observations and information based on our extensive experience over many years helping California, Texas, Michigan, New York, Vermont, Colorado, Georgia, Indiana, Iowa, Massachusetts, Pennsylvania, South Carolina and Virginia by:

- Determining eligibility for more than six million Medicaid and CHIP applicants
- Processing more than 47 million new health plan enrollments and reinstatements
- Answering more than 82 million phone calls
- Pioneering the use of an electronic work environment for programs that have traditionally relied on a manual, caseworker model
- Creating more transactional websites for Medicaid and CHIP programs than any other company
- Being an early thought leader on the Affordable Care Act through the development of white papers, issue briefs and business process analyses

MAXIMUS has developed a number of white papers, issue briefs, and process flow and solution architecture diagrams to assist states in developing exchange solutions. To request this information, please contact us at health@maximus.com.

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July 29, 2011

Dear VHRI Panel Member:

I wanted to take a moment to write to you regarding a few issues related to VHRI's work to bring a Virginia Benefit Exchange to fruition. Before I address the issues, I would like to give you a brief introduction of myself to give you an understanding of my perspective on the issues.

I have worked in the benefits business for over thirty years. Presently I am the COO of TFA Benefits, a wholly-owned subsidiary of TowneBank. Our company works with employer groups from 2 employees to publicly traded companies. We also provide assistance to individuals for their purchase of individual insurance as well as Medicare coverage. On a personal level, I have had the pleasure to be asked to address the VHRI panel on insurance reform (October 20, 2010), as well as past panels organized under the auspices of Jane Kusiak and Patrick Finnerty, exploring the opportunity HIPCs presented to Virginia .

With that said, I understand the challenges that you face to synthesize the multitude of issues and their ramifications. The task is daunting and the decisions made by the panel and ultimately the legislature will have an indelible effect on both the Virginia Benefit Exchange and the private marketplace.

While listening to the panel discussion at the July 15th meeting, it appears some believe an Exchange should not have to comply with existing state mandates. While I understand their argument of limiting the cost to the State, to do so would have a profound effect on the free market and the very people the Exchange is being developed to help. The creation of an Exchange can be a valuable tool to provide more Virginians with coverage, but it could also prove to be very disruptive to the private market if it is created with advantages to the Exchange and if all mandates are not included, the Exchange could be put at a disadvantage.

Virginia has a large number of mandates which account for approximately 20% of the cost of health insurance, all of which have gone through the legislative process and been deemed to be of sufficient value to be enacted into law. All private market insurance carriers offering coverage in Virginia must comply with state laws and provide the mandated benefits to all insureds. If the Exchange is allowed to offer coverage without the inclusion of all of Virginia's mandated benefits, the State would be setting up a two tiered system; one that would make the Exchange set of benefits different (of less value) to the individuals who obtain their coverage through the Exchange. Those individuals would be denied the basic rights provided to all other Virginia citizens. According to the Kaiser Family Foundation 33% of all Virginian's are affected by mandates and The Commonwealth Institute states "if successful, offering health insurance without all mandates included would create an additional class of underinsured Virginians with sub-standard coverage." In order to offer coverage that did not include all state mandates, the Exchange would have to clearly state this defect, which could inhibit the Exchange from gaining traction in the individual marketplace.

Additionally, by setting up a separate and less expensive set of coverages, the Exchange would have a distinct price advantage over the private marketplace. The goal of the Exchange should be to insure more Virginians, not to create a value proposition that encourages business to either enter the Exchange for a lower cost (less mandated benefits will equate to lower premiums) or worse, disband their coverage and direct their employees to the Exchange. This would allow the employer to eliminate the cost sharing arrangement that makes employer sponsored coverage so valuable to the employee.

No amount of administrative savings (economies of scale) will replace the employer paid portion of employee coverage. Employers are required to pay, at a minimum, 50% of their employees' premium. Therefore the cost of coverage for those employees would be more expensive, not less, even if the Exchange would be able to save on administrative costs. By creating an unlevel playing field you run the risk of disrupting and potentially destroying employer group sponsored coverage and having health insurance cost more for employees currently covered under a group sponsored plan.

The other issue I would like to address is the two models of an Exchange that are being discussed; Active Purchaser versus Facilitator. From the discussion it was apparent that some panel members, including Dr. Hazel, were in favor of an Active Purchaser model. While on the surface the ability to negotiate would seem to be in the interest of the Exchange, and therefore Virginians in general, I do not believe that would be true.

An Active Purchaser model would alter the free, private market for health coverage. An Active Purchaser would empower a small group of people (Exchange directors) to make decisions for millions of Virginians. While the private insurance marketplace has had its issues over the years, I trust the power of the market to drive down cost, to create competitive products and quickly react to the changes more so than a panel of well-meaning but insulated individuals. I have never seen a small "think tank" ultimately perform as well as individuals making individual buying decisions about what is best for themselves and their family in a free market setting.

The Facilitator model will assist Virginians in their buying decisions by ranking coverage by objective, transparent standards. This will provide significant pressure on all insurance carriers with the desire to participate in the Exchange to offer quality, cost effective coverage without undue government intervention in the private market.

Virginia is currently in the midst of a lawsuit questioning the legality of individual mandates and by extension PPACA as a whole. Virginia traditionally has taken a conservative approach when faced with major change such as this major decision. The conservative approach in this situation would be to allow other states to experiment with an Active Purchaser model. If they prove to be an asset, Virginia could change the model from Facilitator to an Active Purchaser. In contrast, if the Active Purchaser models adopted by other states (Massachusetts and California) prove to be injurious to those states' private markets, Virginia will not be adversely affected.

Thank you for taking the time to read this letter. If you have any questions or would like to further discuss any of the above issues, please feel free to contact me.

Sincerely,

Richard P. Herzberg
Executive Vice President

Options and Recommendations for the Creation of a Health Benefit Exchange in Virginia

By John A. Lanzalotti, MD

The creation of Health Benefit Exchanges in Virginia provides a unique opportunity to effect real health care reform that will lower costs, introduce transparency, equitable, affordable access, portability and meaningful insurance reform. This opportunity can be realized if the details allow for it not only for the Medicaid and working poor population but for all Virginians.

Our most pressing problem is the reduction of costs. Public funded healthcare is requiring a growing part of the State budget. Rather than resort to price controls and rationing of care we should seek means to create more efficiency, cost effectiveness and reduce fraud and abuse.

Changing the financing of health care will reduce costs more than any other strategy. We should first reduce costs, provide the proper incentives with checks and balances and pay all participants at full, fair market value if we want to lower costs and keep them low. Price controls and rationing don't work. They don't control costs. They do fuel medical inflation and waste, fraud and abuse.
We can eliminate twenty-two cost drivers if we simply change the financing method. Changing the financing of health care will lower costs quicker than any other tactic and meet the least amount of resistance politically.

Our current method of financing health care involves third party payment for the submission of claims for procedures. This is an open ended system that causes the insurance companies both public and private to hemorrhage money, in many cases fails to treat the patient appropriately, and encourages fraud and abuse. In recent years managed care tactics have been used which restrict the practice of medicine to those physicians on "approved" panels. This has failed to reduce costs sufficiently because it is anti-competitive and is a wastes rare and expensive medical talent. It would be better to design proper incentives for physicians and other providers. Even the use of the current forms of prospective payment used in public funded health care fail to reduce costs adequately because they are not designed correctly. Rather, we need to make one payment that covers the cost of the entire episode of care and make available to the patient, in a controlled way, enough money to pay directly for all expenses related to their insurable event so that all providers are paid at full, fair market value. Only in this way can we change the incentives and provide the proper checks and balances that are needed.

We can also eliminate the many state mandates that are imposed on insurance companies by the states by changing the financing of healthcare eliminating the third party payment for which these mandates were written, thereby lowering costs.

This new paradigm also obviates the current government system, which attempts to get all physicians to practice identically, which does not work. It can do this because it uses an automated system that can determine the proper budget for any given patient for their entire episode of care based on their various manifestations of disease and the many appropriate ways physicians have to treat those variations. The technology currently exists. This will discourage the fragmented, episodic delivery of procedures by various doctors associated with today's system. It also prevents physicians from manipulating procedure codes to inappropriately increase reimbursement.

Secondly, reforms need to be made in our design of health insurance. Our current insurance design attempts to cover everything but then fails to do so. It is not really insurance. Insurance is all about risk. "Guaranteed issue" eliminates risk by covering people with pre-existing conditions or who are considered uninsurable. This will drive up premiums dramatically, contributing to the inflation of health care costs. This will happen regardless of legislation prohibiting insurance companies from raising premiums. There are better, more actuarially sound methods to deal with those Americans with chronic illness, pre-existing conditions and are uninsurable that will not inflate premiums or costs than guaranteed issue.

Reforms need to be made to eliminate moral hazard. This reform can be done by bifurcating (splitting into two) coverage between discretionary, price sensitive and non-discretionary, price insensitive events. Actually by bifurcating benefits, we can improve the benefits package in the aggregate. We should only be insuring against non-discretionary, price-insensitive events. This will also dramatically lower insurance premiums and eliminate the need for deductibles and co-pays for insured events which many patients cannot afford. By having the patient control spending for discretionary events from a separate account funded with the premium savings created by the bifurcation and by having the patient use the insurance payments to pay for their care directly, the patients have some "skin in the game" (as well as the money to have skin in the game). According to the results of the Rand Health Insurance Experiment, patients will be more careful spenders of their health care dollar.

It would be less expensive and more efficient to first effect these recommended insurance reforms and then pay the premium for private sector insurance instead of having the government pay for all healthcare directly. Partial premium can come from public funds for those Virginians who cannot afford the full premium.

Most current healthcare regulation involves an expanding bureaucracy and layers of ineffective, opaque regulation. We need regulation that is effective and reduces the cost of a growing bureaucracy. We need a win-win relationship and not an adversarial relationship between all health care market participants where all the participants can thrive and also support what should be the focal point of the market, the doctor-patient relationship. With government acting as referee, all of

the participants in the health care market place need to generate the rules of engagement themselves, i.e. the incentives with checks and balances that are mutually acceptable and subscribe to them with oversight provided by the government (the Health Benefit Exchange) to make sure they comply.

Dr. John Lanzalotti is the policy director of the Jeffersonian Health Policy Foundation in Williamsburg, VA. For a more detailed treatment of the topics mentioned in this white paper contact Dr. Lanzalotti directly. He can be reached at 757-253-2450 or 757-870-4413. His e-mail is : jal@jhpf.org Additional information is on the website www.jhpf.org

Virginia Main Street Alliance Comments on VHRIS Memo, August 26, 2011

The Virginia Main Street Alliance is a statewide network of small businesses.

We want to first thank the Virginia Health Reform Initiative members for their hard work on making Virginia a better place to live and do business. We were impressed at the depth of the report last year and continue to be impressed with the hard work of the task force members.

Small businesspeople are greatly affected by health care costs and agree strongly with the ten principles for a Health Benefits Exchange from last year's report. These ten statements provide a good roadmap for a Health Benefit Exchange that will serve the needs of the state's small businesses. The principles clearly see cost as an important issue, especially for small businesses. But the principles also recognize the value of openness and clarity. Finally, the principles, and indeed much of the long term thinking of the VHRI, focus on wellness and an ultimate goal of a healthier community.

We are also pleased with the VHRI focus on small businesses. The focus groups that were done prior to the July meeting and the survey now underway show a true interest in understanding the needs of small business. The focus groups you held, like the VMSA survey, found high levels of confusion and misunderstanding about the idea of health benefits exchanges. But your focus groups, like our survey, found cost to be the overriding concern of small businesses. Your focus group, like our survey of small business, also found a strong hope that something in this plan will lower health insurance costs for small businesses.

We believe that this hope needs to be a strong focus of the work on the HBE. Too many of our small businesses cannot afford health insurance. Too many of those that do provide health insurance spend too much money, money that could be used for other things like expansions or better pay.

In section 3(h)(i) (3) suggests a goal of "lower premium growth trend off baseline by 10% by 2020, or enough to attract businesses to Virginia". While we support a measurable goal like 10%, the second half of the goal seems most important; we need lower health care cost to strengthen the economy. And we must remember that in this effort to "attract" business, we are competing with the other 49 states as well as with other countries that often have much lower health care costs. Even if we hit the 10% reduction we will fail if other states do better and attract the business. So we cannot let our fear or our perceptions of "how things work" in Virginia keep us from making the decisions that will create the best business climate possible in our state.

We still believe that an "active purchaser model" is the best method to create the best business climate possible in Virginia. It is both factually and intuitively effective. Factually, Massachusetts, using an

active purchaser model reduced health care costs. Intuitively, all of us know that bulk buying power works and works best when it is actively used.

Specific Comments on Questions in Third VHRI Memo:

In general, we believe that that General Assembly should make all of the decisions that it can. The elected officials are in the best position to make the right decisions. The challenge is getting these officials the information and advice that will help them make good decisions. The VHRI has been doing a great job of this and we would suggest that the VHRI continue in operation both to advise the GA and to continue to push for needed long term improvements to health care in Virginia. For now, we would suggest that the VHRI make a recommendation on all of the items included in the major decisions chart from the August 12 VHRI memo. Below are our comments, by topic heading.

We would also support centralizing the oversight functions within the Bureau of Insurance. It makes sense to have one agency doing the many certifications needed and the BOI seems best placed to fulfill this role.

2. Governance (required by HB 2434):

First, all of these items should be in whatever legislation is adopted.

The Virginia Main Street Alliance feels that a new "quasi-public" entity with an 11-15 member board and an advisory committee is a good plan. We support flexibility in hiring, compensation and procurement. We would urge that the appointment process to the board not be too political. We would suggest that some seats on the board be reserved for key stakeholders (consumers, actuarial, nurses, small business etc). We would suggest that the reporting requirements be clear and not onerous (perhaps just a report to the GA once a year). We believe that transparency is critical to the success of the Exchange. Current government transparency rules allow for secrecy in trade secrets and we believe that these current rules will work for the Exchange.

We believe that strong conflict of interest rules need to be in place. We cannot afford for even a hint of self-interest or corporate interest if this is to be accepted by the public. Strong conflict of interest rules will help insure public trust and make sure that the board will be exercising its fiduciary responsibilities in the best interests of everyone in Virginia.

3. Major Policy Directions to be set by Legislature, (all but 3.b may be deferred to Board)

We would suggest that all of these topics be included in legislative authority. Again, the GA is the elected leadership and should step up on these topics. Plus, the GA will learn more about the issue and be in a better place for long term solutions if they have wrestled with all of these topics.

We believe a single administrative authority is critical and we believe a single pool will work better. The board should hire the director and the staff. The board in general should have authority to act, subject

to GA override. We believe that the Exchange needs some authority to take action in the marketplace. We believe strongly that, in order to provide the best business climate and to help small businesses, an active purchaser model is critical. The board also needs authority to consider the quality of health plans. We would support expanding the size limit for a small business up to 100 employees but we believe the GA should decide this. Finally, we believe it is critical for the lower limit to be reduced to one employee and that even a part-time owner should be eligible for a group rate. There are thousands of small businesses that do contribute to our economy, many with the owner as the only employee. We need to take active steps to support them.

4. Delineate the Duties of the Exchange (the following list are the minimum to meet compliance with ACA)

These seem like a good list of duties. These seem to be the kind of details that should be left to the staff/board of the Exchange to work out. We would suggest one more item, working out a system for seamless changes as employees change jobs. Many small businesspeople, when they think about the Exchange, vision a system where they can provide health insurance that the employees can pick up if they lose their job (a little like COBRA but not time limited). There may not be a way to work this out but it should be worth exploring. The other side of the coin (if employees come with insurance can the employer just pick up the tab) may also be worth exploration.

Major Policy Decisions that Could be Delegated Entirely to the Board

This also looks like a good list for the board/staff to handle. Number 4 seems like an important issue that the VHRI should make some recommendations about.

The Virginia Main Street Alliance has no position on the Basic Health Program option. While we see the incredible value to people who "fluctuate" near the line between Medicaid and a subsidy we also know that an option like this could reduce the size and strength of the Exchange, which will be small business's main avenue for progress on health care. We believe that extensive study needs to be made on this issue. We also believe that this is a decision that the General Assembly should make. However, we suggest that the VHRI recommend or conduct a study of the costs, benefits and, especially, the impact on the exchange of a BHP.

Small Business Comments

Please do all you can to help small businesses succeed! Help with health care reform with an active purchaser status would be a huge step to making good healthcare options affordable to all.

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Dear Virginia Health Task Force,

I am a small business owner in Goochland County, VA. Health insurance is a very important issue to me. Not only is it robbing us of income for very little in return (expenses for my HEALTHY family of four average over $15,000 a year with virtually nothing paid out by the insurance company) but it robs all of us of vital discretionary funds we could use to grow our businesses and contribute to the economy.

I fully support Virginia setting up a health benefit exchange. An "active purchaser" model would save money for businesses like mine but for individuals as well. This exchange would need rigorous enforcement and oversight so as keep it efficient. Conflict of interest enforcement is at the heart of this to maintain the integrity of its potential for savings.

I believe bending the cost curve of health insurance in this county is fundamental to turning our economy around. I can't begin to imagine the pick up in business that could be realized by allowing individuals to keep more of the hard earned incomes rather than turning it over to "for profit" businesses that have every interest in taking in as much as possible and paying out as little as possible. That is the business model of an insurance company. It is frankly killing this country.

Respectfully,

Warren Early
Courthouse Service Center
Goochland, VA
804-556-3441

Sir,

I am a small business owner/operator in Richmond with no ability to provide health insurance to myself or my family from my business. As such, I am very much in favor of the State of Virginia setting up a health benefit exchange. It is my belief that an active purchaser model will save both businesses and individuals money, which is critical in these lean times. But let me add one crucial component needed in this model – we MUST have robust conflict of interest rules that ensure that the exchange will work in the best interests of all Virginians.

Thanks for the opportunity to voice my concerns. It's back to work for me.

Best Regards,
Charles Stanton
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Dear Directors Jones and Nichols,

Thank you for the opportunity to submit comments for your consideration on health benefit exchanges. Our comments will be brief and supported by attachments that go into specific topics in more detail. We look forward to the September 9 meeting and the dialogue it will foster. By cc: I am also formally introducing two of my colleagues.

Manny Munson-Regala, former deputy secretary of Commerce for the State of Minnesota and collaborator on the NAIC proposed model legislation for health care reform.

Matthew Caimano, Ceridian's government relations executive for Virginia, and your primary point of contact into our organization for any questions or requests for assistance.

Regarding the memorandum of August 12:

Section I: We commend your specific delineation of goals and points to "keep in mind" that relate to small businesses. With all the dialogue around individual mandates and subsidies, some have given the needs of small businesses and their employees short shrift. The creation of a strong SHOP exchange both will assist the state exchange in becoming self-sustaining, and it creates a positive message of improving the small business climate in your state, which is essential to the health of your state economy.

Section II: You might find it beneficial to also consider the activity of Florida Health Choices, which is establishing a small business marketplace, which bears similarities to the SHOP component of an AHBE.

Section V: It is encouraging that you recognize the critical importance of involving key stakeholders in your policy discussions. Small business owners have turned away from providing insurance to their employees in significant numbers over the past decade. Three reasons drive this behavior: 1. Unpredictable and escalating insurance premiums; 2. Administrative burden on small employers who typically do not have full HR staff; and 3. Dissatisfaction among the employees over the single health plan offered in the employer-sponsored program. A robust SHOP exchange can expand choice and competitiveness, while relieving both the small employer and the insurance carrier of administrative burden. The employer can designate the exchange as a qualified Section 125 (cafeteria) plan, providing a tax incentive for both the small business owner and the employees.

The attached white papers address exchange function and small business benefits to Section 125 plan qualification. We hope they are useful for your discussions, and we look forward to seeing you on the 9th.

Again, thank you for the opportunity to comment. Sincerely,

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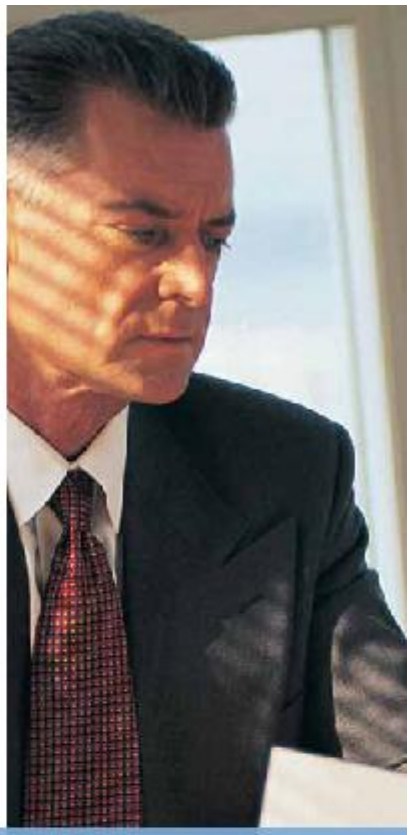
State Briefing



Integration of cafeteria plans with state health insurance exchanges

CERIDIAN

Integration of cafeteria plans with state health insurance exchanges

Under federal tax law, employers may offer their employees the ability to purchase certain employee benefits, including employer-sponsored health insurance coverage, on a pretax basis through "cafeteria plans." That means that employees can pay "less" for their insurance than would have otherwise been feasible. However, the adoption of those plans, especially by small employers, has been sporadic.

Introduction

Under federal tax law, employers may offer their employees the ability to purchase certain employee benefits, including employer-sponsored health insurance coverage, on a pretax basis through "cafeteria plans." That means that employees can pay "less" for their insurance than would have otherwise been feasible. However, the adoption of those plans, especially by small employers, has been sporadic. This is due, in part to the perception by small employers that establishment of such plans entails significant administrative work. This paper examines how cafeteria plans might be integrated with state insurance exchanges. This means cafeteria plans can be used more often, which enhances the value provided by the exchange to the employers purchasing group health insurance coverage through the exchange.

Executive summary

Cafeteria plans offer many benefits to both employers and employees. First, they save taxes for employees and employers by sheltering employee salary-reduction contributions from income and payroll taxes, which reduces the effective cost to employees of contributing toward insurance coverage. A second benefit is that cafeteria plans also play a critical role in ensuring employer compliance with ERISA's plan assets and trust requirements. In addition, with the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), small employers may now use "simple" cafeteria plans to automatically satisfy nondiscrimination requirements applicable to certain employee benefits programs funded through the cafeteria plan.

Cafeteria plans offer many benefits to both employers and employees. First, they save taxes for employees and employers by sheltering employee salary-reduction contributions from income and payroll taxes, which reduces the effective cost to employees of contributing toward insurance coverage. A second benefit is that cafeteria plans also play a critical role in ensuring employer compliance with ERISA's plan assets and trust requirements.

States have recognized these benefits and taken legislative action in recent years to encourage the use of cafeteria plans by employers. Despite the known benefits and the efforts by states to promote cafeteria plans, many employers still do not use cafeteria plans. The principal reasons appear to be concerns over administrative complexity, cost and compliance.

These concerns could be substantially overcome by integrating a cafeteria plan option with a state insurance exchange. Beginning in 2014, small employers (generally meaning employers with no more than 100 employees) will be eligible to purchase group health insurance through the Small Business Health Options Program (SHOP) portion of a state exchange. A cafeteria plan option integrated with that exchange would help ensure employee contributions to that coverage are processed on a pretax basis and that employers do not inadvertently fail to discharge certain obligations under ERISA. Beginning in 2017, this favorable treatment could be extended to all employers purchasing group health insurance coverage through the exchange.

Substantial value would be added to the state insurance exchange by integrating a cafeteria plan. And doing so would create a platform for delivering other value-added benefits and services through the exchange, such as wellness programs, consulting and advice for purchasers, coordination with subsidies, and optional expanded cafeteria-plan benefits, such as flexible

spending accounts. All of this together would enhance the significance and sustainability of the exchange, while promoting state-favored policies.

A cafeteria plan is a written plan that permits employees to choose between the receipt of cash and one or more "qualified benefits."

What is a cafeteria plan?

A cafeteria plan is a written plan that permits employees to choose between the receipt of cash and one or more "qualified benefits."[1] Qualified benefits are those that are otherwise nontaxable under a specific provision of the Internal Revenue Code, such as employer-sponsored health insurance coverage. A cafeteria plan allows employees to electively divert taxable compensation to pay for these qualified benefits on a pretax basis.

Tax benefits of a cafeteria plan

When compensation is applied to pay for benefits under a cafeteria plan on a pretax basis, that compensation is exempt from federal income and FICA taxes. In some states, it is also exempt from state income taxation. This can result in significant tax savings to employees and employers. For employees, this increases the amount of their take-home pay, effectively subsidizing the out-of-pocket cost of purchasing coverage. For employers, it excludes the pretax amounts from the employer's share of FICA taxes, generally resulting in a savings of 7.65 percent on all dollars withheld through the cafeteria plan.

> **Example.** An employee earns $20,000 per year and is in a 10 percent federal income tax bracket. FICA taxes are withheld from the employee's wages at the rate of 7.65 percent, and the employer pays FICA taxes on the employee's wages at the same rate. The employee will spend $4,000 during the year to pay for health insurance premiums. If the employee cannot pay those premiums through a cafeteria plan, the employee must pay federal income tax and FICA tax of $3,350 on the full $20,000 of the employee's wages. The employee will have only $12,470 remaining after payment of the federal taxes ($3,530) and health-insurance costs ($4,000). But if the employee can pay the premiums through a cafeteria plan, the employee's taxes will be reduced to $2,824, which increases the employee's take-home pay by $706. Additionally, the employer saves $306 in FICA taxes it otherwise would have paid (.0765 x $4,000 = $306).

Because cafeteria plans allow employees to electively convert taxable wages into nontaxable benefits, federal tax regulations impose significant restrictions on the employee's ability to make or change those elections each year. As a general rule, an employee may only make or change an election under a cafeteria plan during an open-enrollment period held before the beginning of the plan year.

Compliance considerations for cafeteria plans

Because cafeteria plans allow employees to electively convert taxable wages into nontaxable benefits, federal tax regulations impose significant restrictions on the employee's ability to make or change those elections each year. As a general rule, an employee may only make or change an election under a cafeteria plan during an open-enrollment period held before the beginning of the plan year. A few narrow categories of midyear election changes are permitted, such as changes due to special enrollment rights or changes in family or employment status. But the changes are tightly regulated and must be strictly applied in order to preserve the beneficial tax treatment of the cafeteria plan.

[1] *Internal Revenue Code § 125(d) (26 USC § 125(d)).*

The Internal Revenue Code also imposes nondiscrimination requirements on cafeteria plans to ensure the plans are not utilized disproportionately to benefit highly compensated employees. In general, a cafeteria plan may not discriminate in favor of highly compensated employees as to eligibility, benefits or contributions. Additionally, key employees may not disproportionately utilize a cafeteria plan so that more than 25 percent of the aggregate benefits provided under the plan are provided for key employees. Separate nondiscrimination requirements may apply to underlying substantive benefit arrangements funded through a cafeteria plan. These include medical benefit plans (including health care flexible spending account arrangements) and dependent care assistance plans. Compliance with these nondiscrimination requirements generally can be assured only by periodic testing.

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In 2007, the IRS issued comprehensive proposed regulations for cafeteria plans; however, they have not yet been finalized. On the whole, the proposed regulations do not substantially change the compliance requirements associated with cafeteria plans. But there are some notable exceptions. The proposed regulations confirm that a cafeteria plan must not only be maintained pursuant to a written plan document, but it must also provide a specific description of the benefits available under the cafeteria plan. The regulations also provide additional detail regarding the nondiscrimination rules applicable to cafeteria plans, and it is anticipated that enforcement of those standards will increase once final rules are published.

ERISA, plan assets, and the trust requirement

Beyond the technical requirements applicable to cafeteria plans under the federal tax code, most employers (other than churches and governments) must consider their compliance obligations under the federal Employee Retirement Income Security Act of 1974 (ERISA). This includes the mandate that all assets of an employee benefit plan must be held in trust. Specifically, employers subject to ERISA must be cognizant of whether or when the amounts they withhold from employee pay to cover benefit costs are plan assets and must be held in trust.

A regulation from the federal Department of Labor (DOL) provides a succinct rule on this point. For welfare benefit plans, amounts withheld from employee pay become plan assets on "the earliest date on which such contributions can reasonably be segregated from the employer's general assets," but in no event later than 90 days after the date on which the employee contributions are received by the employer.[2] Thus, employee contributions may be plan assets as soon as the payroll date on which the contributions are withheld from employee pay if that is the date on which they can reasonably be segregated from the employer's general assets.

Under a technical application of these rules, amounts withheld from employee pay to cover employee contributions to health insurance and other benefits almost always would be required to be held in trust. If the funds are not held in

[2] *29 CFR § 2510.3-102(a), (c).*

trust, the fiduciary of the employee benefit plan (typically the employer who sponsors and administers the plan) will have breached its fiduciary duty under ERISA to hold all plan assets in trust.[3]

Aside from that, the federal DOL has a long-standing enforcement policy. Under its policy, it will not assert a violation of the ERISA trust requirement for failure to hold employee contributions to welfare benefit plans in trust if those contributions are withheld from employee pay through a cafeteria plan. This policy is described in DOL Technical Releases numbers 88-1 and 92-01.

The rule is simple: An employer must either utilize a cafeteria plan to withhold employee contributions from pay or hold employee contributions in trust. Experience indicates that very few employers — particularly small employers — utilize trusts in connection with their employee health insurance programs and other contributory welfare benefit plans. Thus, the utilization of a cafeteria plan in connection with an employer-sponsored insurance program is critical to ensure compliance with the substantive requirements of ERISA.

Cafeteria plans are primarily a feature of federal tax law. They impact state tax law derivatively in some states, such as Kansas, that determine state taxable income as a function of federal taxable income. But state law does not substantively regulate cafeteria plans.

Cafeteria plans and state law

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The benefit of cafeteria plans to both employees and their employers has not been lost on the states, however. Thirteen states have encouraged the use of cafeteria plans by employers through legislation mandating the creation of such plans or in some cases, providing direct financial incentives.[5]

For example, in 2008, the Kansas legislature passed Senate Bill 81,[6] which made two significant changes to the interaction between Kansas insurance law and cafeteria plans.

1. **Under Section 1 of 2008 Senate Bill 81** (now codified at K.S.A. 40-2260), insurers writing group health coverage in Kansas are required to offer the option of establishing a cafeteria plan. These insurers are authorized to charge a fee for this service and to utilize outside vendors in offering the plans.

2. **Under Section 2 of 2008 Senate Bill 81** (now codified at K.S.A. 40-2261), employers purchasing group health insurance are expressly authorized to establish cafeteria plans in connection with the offering of that group coverage to their employees.

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[3] *See ERISA § 403 (29 USC § 1103).*

[4] *State wage payment laws impact the manner in which employees must authorize pretax wage withholdings under cafeteria plans, but those rules do not impact the substantive features of cafeteria plans.*

[5] *See NCSL table of cafeteria plan activity at http://www.ncsl.org/?tabid=14515.*

[6] *2008 Kan. Sess. Laws ch. 164.*

PPACA made two important changes to the federal cafeteria-plan rules, particularly as they apply to small employers. Beginning in 2011, small employers may adopt "simple" cafeteria plans that will automatically satisfy applicable nondiscrimination rules. Beginning in 2014, small employers purchasing group insurance coverage through the Small Business Health Options Program (SHOP) portion of a state insurance exchange may use a cafeteria plan to finance employee contributions to the premiums for that coverage. This option may extend to large employers as well, beginning in 2017.

Cafeteria plans and PPACA

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Simple cafeteria plans

An employer with an average of 100 or fewer employees on business days during either of the two preceding years is eligible to establish a simple cafeteria plan for any year beginning on or after January 1, 2011.[7]
Two substantive requirements must be met to create a qualifying simple cafeteria plan: [8]

1. ***Minimum Eligibility*** — Participation in the simple cafeteria plan must be offered to each employee who completed at least 1,000 hours of service during the prior plan year. Each employee who becomes eligible for the plan must be eligible to elect each qualified benefit offered under the plan. Certain classes of employees may be excluded from participation, including employees who have not yet reached age 21, employees who have not completed one year of service, employees who are covered by a collective-bargaining agreement and foreign employees who are not U.S. citizens or residents.

2. ***Minimum Contribution —*** The employer must provide a minimum contribution toward the cost of benefits available under the cafeteria plan for nonhighly compensated employees. This can be satisfied in one of two ways: (1) The employer can make a fixed contribution equal to a uniform percentage of compensation that is at least 2 percent; or (2) the employer can make a dollar-for-dollar matching contribution up to a specified percentage of compensation that is at least 6 percent.

If these requirements are satisfied, the cafeteria plan and all optional benefit plans offered in connection with the cafeteria plan are deemed to satisfy applicable nondiscrimination requirements. Applicable nondiscrimination requirements are those that apply directly under the cafeteria-plan rules (Code Section 125) and those that apply indirectly under other code sections governing benefits offered in connection with the cafeteria plan. Significantly, this includes the nondiscrimination requirements that apply to self-funded group health plans under Code Section 105(h) and — under Section 2716 of

[7] *See Internal Revenue Code § 125(j) (26 USC § 125(j)).*

[8] *For further explanation regarding these requirements, see Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act", JCX-18-10, pp. 118-19 (Mar. 21, 2010).*

the Public Health Service Acts, as amended by PPACA — now apply to fully insured group health plans as well.[9]

To be sure, there is a cost associated with utilizing a simple cafeteria plan. The employer must contribute as much as 6 percent of the compensation of participating employees. But the significance of this new option should not be understated, particularly because it gives qualifying employers a means of automatically complying with the nondiscrimination requirements under Code Sections 125 and 105(h). Although many such employers would otherwise design their plans to comply with these requirements, the ongoing costs of monitoring compliance with these requirements (testing and self-audits) is substantial and likely to become only more so as further emphasis is placed on audit and enforcement in future years. That alone could justify the additional expense associated with the required contributions to the simple plan.

Group insurance coverage purchased through a SHOP exchange

PPACA amended the cafeteria plan rules under Code Section 125 to make clear that individual insurance coverage purchased through a state's American Health Benefit Exchange is not a qualified benefit for cafeteria plan purposes and may not be purchased on a pretax basis through a cafeteria plan.[10] Group coverage, however, is treated differently. "Qualified employers" who elect to purchase group coverage for their employees through the SHOP portion of a state's insurance exchange established under Section 1311(b) of PPACA (42 USC § 18031(b)) may offer that coverage through a cafeteria plan.[11]

Qualified employers for this purpose generally are defined under Section 1312(f) (2) of PPACA (42 USC § 18032(f) (2)) as employers with no more than 100 employees. However, for the years before 2016, states may elect to reduce the cap for small-employer status to 50 employees. In this case, only those small employers would be qualified employers for this purpose. For years beginning in 2017 or after, states may elect to permit group insurance coverage for large employers (more than 100 employees) to be offered through the SHOP exchange. In this case, all employers purchasing group coverage would be qualified employers for this purpose.

Although at first glance the cafeteria-plan rules appear quite restrictive in their interaction with insurance coverage purchased through a state exchange, they are actually quite robust when viewed in the context of employer-sponsored group insurance plans, particularly those plans offered by small employers.

Although at first glance the cafeteria-plan rules appear quite restrictive in their interaction with insurance coverage purchased through a state exchange, they are actually quite robust when viewed in the context of employer-sponsored group insurance plans, particularly those plans offered by small employers. Beginning in 2014, a substantial number of employers within a state — all those with 100 employees or less — will be eligible to purchase group insurance coverage through SHOP exchange, and that coverage could be offered through a cafeteria plan. By 2017, this could expand to encompass all employers within a state that elect to purchase group insurance coverage through a SHOP exchange.

[9] Compliance with these nondiscrimination requirements by fullyinsured plans is not currently being enforced by the IRS, pending the issuance of formal guidance on their application. See IRS Notice 2011-1. However, the requirements are anticipated to have a significant impact on employers sponsoring fully-insured plans once enforcement commences.

[10] See Internal Revenue Code § 125(f)(3)(A) (26 USC § 125(f)(3)(A)).

[11] See Internal Revenue Code § 125(f)(3)(B) (26 USC § 125(f)(3)(B)).

Employer use of cafeteria plans

Despite the known benefits of using cafeteria plans to purchase employer-sponsored health-insurance coverage, many employers — particularly small employers — remain reluctant to utilize them, even when offered incentives to do so.[12] The primary concerns of those employers are cited as cost and compliance concerns.

Minnesota's example is illustrative of the difficulties small employers have had in setting up cafeteria plans. Beginning on July 1, 2009, Minnesota law required employers who 1) do not offer health insurance benefits to their employers and 2) had 11 or more full-time equivalent employees to establish and maintain a Section 125 plan to allow their employees to purchase health coverage with pre-tax dollars.

To further incent employers to set up these plans, the Minnesota Department of Employment and Economic Development was directed to award grants up to $350 to set up such plans. Employers could opt out of this requirement by certifying to the Commissioner of Commerce that they had received education and information on the advantages of Section 125 plans and chose not to establish such a plan. As of the date of this state briefing, six businesses had received the grant. Most businesses cited fears about administrative difficulty and legal liability as reasons why they have not complied.

Concerns about cost may reflect a lack of full understanding regarding the benefits associated with a cafeteria plan. The employer's tax savings alone are often sufficient to cover any out-of-pocket costs attributable to sponsoring and administering the plan. It is also permissible to pass certain plan administrative expenses through to participants on a pretax basis if the employer does not want to pay those expenses as an additional benefit for its employees.

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Concerns about compliance, on the other hand, are real. To receive the tax benefits associated with a cafeteria plan, it must be established and operated strictly in accordance with the governing requirements. There must be written documentation that specifically describes the benefits offered. Employee elections may only be made and changed at limited times. Nondiscrimination requirements must be satisfied.

For most employers, maintaining a cafeteria plan is essential to complying with the ERISA trust requirements. Without the cafeteria plan, employee salary-reduction amounts may be plan assets within the meaning of ERISA; employers would be violating their fiduciary duties if they do not hold the assets in trust. So while compliance issues are associated with maintaining a cafeteria plan, there are equal, if not greater, compliance issues associated with not maintaining a cafeteria plan in connection with group health insurance offered to employees.

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[12] *See generally Hall et al., supra note 7.*

[13] *See DOL Technical Release 92-01; Prop. Treas. Reg. § 1.125-1(r)(1).*

A SHOP exchange should offer employers the opportunity to adopt a cafeteria plan that is integrated with the exchange and administered in connection with the exchange. Access to the cafeteria plan and ongoing support of the cafeteria plan would be provided as an exchange-integrated service, much like computer software that is accessed as a service (so-called software as a service or SaaS) rather than purchased on a stand-alone basis in shrink-wrapped packages.

A win-win-win solution: cafeteria plans and exchanges

The establishment of state insurance exchanges under PPACA presents a unique opportunity to implement a solution to this cafeteria plan conundrum that benefits all parties involved (the employer, the employees, and the exchange).

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The benefits of this approach are clear:

- ***For the employer,*** access is provided to a cafeteria plan program that will enable the employer to enjoy the tax benefits associated with maintaining a cafeteria plan without going it alone on the compliance side. Economies of scale associated with the exchange permit the design and maintenance of a cafeteria plan program on a cost-effective basis. This includes providing access to innovative new plan designs, such as the simple cafeteria plan option now available under PPACA and providing ongoing compliance support. Most importantly, however, this approach ensures that employers purchasing group coverage through the exchange are not inadvertently violating their obligations under ERISA by failing to withhold employee contributions through a cafeteria plan or by placing the contributions in trust.

- ***For the employee,*** the opportunity to contribute toward the cost of coverage on a pretax basis increases take-home pay. This creates parity with employees of larger employers who have historically offered this option. It also will contribute materially to the realization of state policy objectives to increase access to cafeteria plans by employees.

- ***For the exchange,*** employers can obtain value-added benefits and services in connection with the purchase of group insurance coverage through the exchange. This may be expected to increase the utilization of the exchange by employers, particularly small employers. This will contribute toward the intangible success of the exchange in creating a meaningful marketplace for group insurance in the state. On a more practical level, it may well increase revenue to the exchange, thereby contributing to the exchange's ability to be self-sustaining.

Needed: a value-added exchange

For an exchange to provide an integrated cafeteria plan, an exchange capability that goes beyond merely referring purchasers to sellers is required. To support an integrated cafeteria plan, an exchange should consider being a value-added exchange, which would include providing the following services:

- aggregate premiums and integrate with payroll,
- ensure compliance with the requirements of section 125,
- provide targeted and ongoing communications with employers and employees,
- support customers online and via phone and
- provide some degree of claims processing.

Implementing a value-added exchange provides the platform necessary to integrate a cafeteria plan option with the exchange. It also provides other benefits and services that will enhance the status of the exchange and contribute toward realization of state goals and policies with respect to health care coverage, cost, understanding and general wellness.

Indeed, it may be said that a value-added exchange offering the cafeteria plan option and other specialized benefits and services may be the only way to establish a meaningful exchange-based insurance program in the state. Without the cafeteria plan option, employers and employees will likely experience higher tax costs associated with their coverage, given the known reluctance of many employers to independently adopt cafeteria plans. Employers who withhold employee compensation to contribute toward premiums may well, in the absence of a cafeteria plan, fail to comply with the ERISA trust requirement.

In terms of cost, specific financial analysis is warranted. However, increased exchange traffic attributable to specialized benefits, such as the cafeteria plan option, may be enough to justify costs associated with the value-added exchange approach. If not, costs may be passed through to employers purchasing coverage through the exchange. This may include commission-like fees associated with the purchase of coverage or by charging additional fees for accessing the specified services (or both).

Other benefits of value-added exchanges

Of course, the opportunity to access a cafeteria plan program through an exchange is not the only benefit or service that might be offered. It is but one of many. Other examples include:

- **Wellness —** Wellness programs are recognized as an important means of improving individual health and health care outcomes, beyond merely providing access to coverage. The value-added exchange provides a platform for designing and delivering a wide range of wellness options and information to those purchasing coverage through the exchange.

- **Consultation and Advice —** Those who purchase insurance (both individuals and employers) and participate in the exchange may benefit from access to analysis and guidance that can be provided to them by knowledgeable resources about the features of the various options available through the exchange. The value-added exchange provides a platform for access to agents or consultants who can advise purchasers about the available options and receive compensation for their services.

- **Subsidies and Accounting —** Some who purchase coverage through the exchange may qualify for subsidies and various forms of cost assistance in purchasing that coverage. The value-added exchange provides a platform for integrating the flow and allocation of those dollars in a centralized and efficient manner.

- **Flexible Spending —** Cafeteria plans are permitted to provide benefits beyond pretax treatment of insurance contributions. These include flexible spending accounts that allow employees to pay for out-of-pocket health care and child care expenses on a pretax basis. The value-added exchange allows incorporating these additional cafeteria plan features, thereby amplifying the pretax purchasing power to employees of employers who might not otherwise offer those programs.

Conclusion

Providing employer access to a cafeteria plan program in connection with the state insurance exchange yields substantial benefits for employers, employees and the exchange. It reduces taxes, improves compliance, advances state policies and establishes a self-sustaining exchange program that provides access to coverage and meaningful value-added services and benefits.

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About Ceridian:

Headquarters — Minneapolis, MN. With more than 130,000 clients who have 25 million employees, Ceridian currently manages $160 billion a year in financial transactions and is one of the nation's largest HR/payroll providers. The company is also one of the most experienced providers of COBRA premium administrative services, offering expertise in processing premium billing and applying subsidized rates. In addition, Ceridian provides benefit eligibility and enrollment services to large and small employers, as well as decision-support tools that help employees make better health plan choices. Ceridian's health and wellness programs are ranked high within the industry for achieving both significant employee participation and bottom line results. Ceridian was awarded the Florida Health Choices insurance marketplace contract in October 2010. For more information about Ceridian's Exchange Services, please visit us at www.ceridian.com/exchange or call 800-729-7655.

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State Briefing

Essential functions of a SHOP exchange

CERIDIAN

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This is the first of a series of Ceridian published white papers that will examine the complexities of each of the essential functions of a SHOP exchange.

Introduction

The Patient Protection and Affordable Care Act (PPACA) requires states to establish health insurance exchanges serving the individual and small group markets by 2014, or else have the federal government do so on their behalf. According to official estimates, state American Health Benefits Exchanges (AHBEs) will collectively serve more than 24 million individuals annually by 2019, while the Small Business Health Options Program (SHOP) exchanges will enroll 5 million people in small group employer-sponsored insurance by that same time.[1] The disparity in these numbers belies the significance of a vibrant small group market in the post-PPACA era and fails to capture the critical importance of a well-functioning small business exchange to a state's economic growth and financial well-being.

This paper highlights some of the key ways state-based SHOP exchanges can help states improve access to health coverage, expand competition for health insurance programs, and moderate the cost of health care. However, SHOP exchanges will succeed in helping states reach these goals only to the degree that they are able to attract a vibrant, diversified pool of risk. While individuals must purchase insurance through the AHBE to receive federal tax credits and cost-sharing subsidies, there is no equivalent "hook" for the SHOP. Instead, SHOP exchanges will be competing with the traditional small group market in the states — albeit under the new insurance market rules adopted in PPACA.

Moreover, the exclusion of employers with less than 50 full-time workers from the "employer responsibility" provisions of PPACA, coupled with the individual support provided through the AHBE, means that businesses will have a strong financial incentive to abstain from offering coverage. SHOP exchanges must be carefully constructed to appeal to eligible employers, employees and insurers. If they are not, a large swath of the 37 million people who currently receive their health care benefits from small employers could flock to the AHBE. This realignment could overwhelm the individual exchanges logistically, undermining one of the original intents for creating exchanges: lessening the complexity and administrative burdens associated with traditional health care insurance.

The keystone to a successful SHOP exchange

To thrive in this environment, a small business insurance exchange must offer recognizable value and real relief to employers struggling with the cost and complexity of providing health care coverage to their workforces.

[1] *Congressional Budget Office, Letter to Hon. Nancy Pelosi, Mar. 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf*

There are three major constituencies to consider in designing a SHOP exchange:

- Employers offering coverage
- Carriers providing coverage
- Individuals receiving coverage

While each one of these constituencies has unique interests and needs that must be satisfied to build a functional market, the primary variable in the SHOP equation is the employer. A market that is attractive to a wide range of employers will automatically generate interest from insurers. This, in turn, will help drive competition among insurers, which should ensure an appealing offering of plan options, benefit packages and premiums from which employees can choose and begin to drive down health care costs over time.

State officials must develop a strong understanding of the functions that are key to making a SHOP exchange attractive to small employers, based on the needs of these employers and utilizing the many services that are currently available in the commercial marketplace.

The 8 key elements to creating value for small employers :

1. Employee choice

2. Defined contribution

3. Section 125 support

4. Premium aggregation

5. Payroll administration

6. Life event management

7. Broker involvement

8. Supporting all parties

Developing the employer value proposition

A successful SHOP exchange will focus on adding value to participating employers — in terms of both the cost and diversity of the insurance options it offers and in the valuable services it provides those employers. SHOP exchanges must give small employers access to the same choices, efficiencies and economies of scale already enjoyed by large employers, while simultaneously reducing small employers' administrative burdens. Additionally, SHOP exchanges can be designed to give employers the ability to let their employees choose their own plans: Employee choice can be a powerful attractor for small businesses exploring ways to best provide health insurance to a diverse workforce.

SHOP exchanges that can help to facilitate employee choice, defined contribution, broker engagement and payroll and life-event management are positioning themselves for success. The critical success factors, however, might be those that can help small businesses with the transition to an adjusted benefits model. All these elements combined are important to a service that employers can leverage to help meet the requirements of PPACA while creating tremendous value for their businesses and their employees.

Facilitating employee choice

Defined contribution Employers have long been forced to endure and absorb much of the rising cost of health care. In many cases, these costs have affected their ability to compete in the marketplace. Because of these dynamics, innovative payment designs, such as the defined contribution model at the center of Utah's exchange, could serve as a potential draw for employers to offer benefits through a SHOP exchange. A well-designed contribution model can transform health care costs from unpredictable to predictable; while at the same time provide employees with a broader range of personal choice.

The payroll administration function is critical not only to employee choice, but also to any SHOP exchange that offers employers the feature of "defined contribution." Employers want certainty around health care costs. One reason small employers have not been able to offer multiple-plan choices to their employees is because of the traditional practice of having to pay a percentage of employee's health insurance premiums. This results in greatly varying costs on a month-to-month basis if each employee has a different policy. A SHOP exchange, on the other hand, allows employees to choose the plan they want, but also allows the employer to pay a "defined contribution," or specified dollar amount, instead of a percentage of each employee's costs. By providing an effective payroll administration function, combined with an effective aggregator that could bundle payments from multiple sources, a SHOP exchange can create the option for employers to make a defined contribution toward their employees' health insurance instead of making traditional percentage contributions.

Section 125 plan support Many small employers feel challenged when it comes to choosing a health plan for their employees; they recognize that the needs and preferences of individual employees and their families are inherently diverse. Moreover, since employers usually have very little choice of affordable plans in the small group market, providing viable options to their employees is often impossible. SHOP exchanges can overcome this challenge by permitting the employer to designate the SHOP as its Section 125 "cafeteria plan" under federal tax law. Once the employer does this, its employees can purchase coverage from a range of plans offered by the SHOP and approved by the employer (possibly via the choice of a "tier" of coverage, to which the employer agrees to contribute). The employer can complete a simple form online as part of its company's registration to authorize the process and subsequently be relieved of all administrative work in this area.

Just as important, the designation of a SHOP exchange as an employer's "cafeteria plan" means that the employee can use pre-tax dollars to purchase insurance at a savings of approximately one-third of the after-tax cost for most individuals. This is a strong financial incentive and can prevent employers from dropping coverage and sending their employees to the AHBE. Under PPACA, individuals who purchase insurance through the AHBE must use post-tax dollars. This may not be a problem for those who are eligible for federal tax-credit and cost-sharing subsidies. It might present a challenge, however, to those above 400% of the Federal Poverty Level (FPL) who will be paying the full

premium themselves. Since non-discrimination provisions prevent a company from offering full-time employees different benefits based on their salary, an employer would be unable to segment non-subsidized employees from those receiving subsidies. The SHOP exchange alleviates this problem by providing a vehicle through which all employees can purchase coverage with pre-tax dollars that are matched by their employer's contribution.

Aggregation Aggregation, sometimes referred to as premium aggregation, is the other half of the payroll administration function in a SHOP exchange. Aggregation takes the employer's contribution and combines it with the employee's payment to make a single payment to an insurer. This reduces insurers' overhead costs by dramatically reducing the number of payments they are pursuing every month — a huge incentive for them to participate in the SHOP exchange. In addition, it allows carriers to pass on these savings to their SHOP customers.

A SHOP aggregator can leverage this function even more than a traditional aggregator can. A SHOP aggregator would have the ability to combine payments from multiple sources, including multiple payments for the same line of coverage. For example, if an individual had purchased family coverage, a SHOP exchange could receive payments from both the owner of the insurance and from the spouse. A robust SHOP exchange aggregator would allow the contributions of both of those individuals to be combined into one employee contribution toward the premium payment on a family plan, if the employee so chooses. Such an arrangement would provide maximum flexibility not only for employers and employees, but also for those states that use Medicaid funds to support premium payments for employees eligible for Medicaid coverage.

Payroll administration and life-event management Small employers traditionally look to a third-party administrator to deduct premium payments from employee payrolls, then combine those with contributions from employers and make a single payment to each insurer providing a plan option. This time-consuming process has led many small employers to limit the number of health plan options they offer to their employees. Offering payroll administrative services, as a SHOP function, would simplify the process of offering a broad range of plan options for small employers, relieving a significant administrative burden.

The ability to limit the effects of inevitable "life events" for individuals and to support small businesses in managing these processes is another potential draw for SHOP exchanges. These services could include transitioning employees to COBRA health care continuation coverage or to other supplemental coverage, facilitating coverage adjustments based on changes in personal circumstances (e.g., marriage, divorce, death of a spouse or birth of a child), or allowing employees to receive new quotes after a move to a new area of coverage. Such transitions consume a great deal of time and effort for small employers in the form of lost work hours, added paperwork and disruptions in coverage. All could be handled by a full-service SHOP exchange.

Supporting broker engagement The selection and purchase of health insurance is a complex decision for most employers as well as for their employees. The dramatic changes that will occur as a result of PPACA are likely to increase confusion and complicate personal health care decisions. We can expect the number of questions that employees and employers will have about health insurance to escalate. Because of this, the SHOP exchange should include multiple support systems and prominent promotional and education functions.

Historically, the small business community has relied on health insurance brokers to provide much of this support. SHOP exchanges can be designed to continue and enhance the vital role of the broker as a means of support for both employer and employee. In this way, not only are brokers able to assist employers in the transition to exchanges, but they can also benefit from additional access to employers who are now able to offer coverage through the SHOP exchange.

Helping all constituents transition to a SHOP Finally, a SHOP exchange should offer real-time access to information for employers, employees and brokers. Rightly so, most of the current market focus has centered on the use of the Web to help efficiently administer plans and facilitate individual choice. Online support tools can provide individuals with the right information at the right time. These tools typically include plan filters, premium calculators, access to billing history, and the ability to interact with an exchange.

While Web-based technology is central to the success of an exchange, SHOP design should also consider offering English and non-English speaking phone and fulfillment for those businesses and individuals who are not able to access the information via a computer. This is especially important to those states with large rural populations or other populations that may not have access to a computer. A synergy of Web-based and paper- and phone-based tools can help all involved navigate the SHOP exchange experience.

Conclusion

The establishment of a sustainable SHOP exchange by 2014 presents serious challenges to state governments. But this fast-approaching PPACA requirement also presents an unprecedented opportunity: Legislators not only can take a lead role in determining what the future of health care should look like in their states, but they can help support those small employers that are so crucial to innovation and economic growth, and that create millions of new jobs every year. The stakes are high for all involved. The good news is that the functions and services required to make a SHOP exchange successful are available right now. In fact, many of these capabilities are used with great success today in the commercial health benefits market.

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About Ceridian:

Headquarters — Minneapolis, MN. With more than 130,000 clients who have 25 million employees, Ceridian currently manages $160 billion a year in financial transactions and is one of the nation's largest HR/payroll providers. The company is also one of the most experienced providers of COBRA premium administrative services, offering expertise in processing premium billing and applying subsidized rates. In addition, Ceridian provides benefit eligibility and enrollment services to large and small employers, as well as decision-support tools that help employees make better health plan choices. Ceridian's health and wellness programs are ranked high within the industry for achieving both significant employee participation and bottom line results. Ceridian was awarded the Florida Health Choices insurance marketplace contract in October 2010. For more information about Ceridian's Exchange Services, please visit us at www.ceridian.com/exchange or call 800-729-7655.

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